

**RESIDENTIAL RESPITE**

Consumer Name: \_\_\_\_\_ Consumer SSN: \_\_\_\_\_

DSN Board/Private Provider: \_\_\_\_\_

**Proposed Respite Description**

Residential Program In Which Respite Is To Be Provided: \_\_\_\_\_

Type of Residential Program (e.g., CTH I, CTH II, CRCF, ICF/MR): \_\_\_\_\_

Estimated Duration Of Respite (Dates): \_\_\_\_\_

Reason For Respite:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Is there sufficient licensed bed capacity to accommodate respite? \_\_\_\_ Yes \_\_\_\_ No

Is consumer to receive respite compatible with other consumers residing in home? \_\_\_\_ Yes \_\_\_\_ No

Have other consumers agreed to respite? \_\_\_\_ Yes \_\_\_\_ No

Has other consumer agreed to use of bedroom (if applicable)? \_\_\_\_ Yes \_\_\_\_ No

Proposed Resolution (if "No" checked on either of three previous questions): \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**DSN Board/Private Provider Certification**

I hereby certify that the information contained in this report is accurate.

\_\_\_\_\_  
Executive Director Signature

\_\_\_\_\_  
Date

**SCDDSN Approval**

\_\_\_\_\_  
Assistant District Director

\_\_\_\_\_  
Date

\_\_\_\_\_  
District Director

\_\_\_\_\_  
Date

**(submit to DDSN District Office Assistant District Director)**